

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JAN 23 1941

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

44078

Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis

Registration District No. 840

(b) Township St. Louis

Primary Registration District No. 6102

(c) City St. Louis

(d) Street No. 2

(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred

yrs. mos. ds.

(f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Dealin M. Peyton St. ☐

(Usual place of abode, if no street address, write county or city)

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Charlie Peyton

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan-17-1886

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

54

11

03

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

House wife

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Puerto Rico, MO

FATHER

13. NAME Frank Gaines

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Puerto Rico, MO

MOTHER

15. MAIDEN NAME Anna Welfing

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Puerto Rico, MO

17. INFORMANT (ADDRESS) Charlie Peyton

18. BURIAL, CREMATION, OR REMOVAL

PLACE Funeral Home

DATE Dec 15-20

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Walter M. Peyton

20. FILED 12-15

1941

Demaria Dupont

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec-14, 1940

22. I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1937, to Dec 14, 1940

I last saw her alive on Dec. 14, 1940. Death is said to have occurred on the date stated above, at 6:20 m.

The principal cause of death and related causes of importance were as follows:

Lung Emphysema

Date of onset

Other contributory causes of importance:

Chronic Bronchitis

Name of operation no Date of no
What test confirmed diagnosis Clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Dr. John H. M. M. M.

(Address) Physician, Mo.

Licensed Embalmer's Statement on Reverse Side)

10341

RECEIVED

District Health Officer N

District File Number 141-1

Date Filed 1/8/4

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, _____

Virgil H. Welch

, or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Virgil H. Welch

Licensed Embalmer No. _____

4102

P. O. Address _____

Depton - Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 44078

Registration District No. 840

Primary Registration District No. 6102

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Stoddard
(b) City or town Beck Creek T.P.
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether

In this community _____
years, months or days)

3. (a) PRINT FULL NAME

Dealia M. Payton

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7

5. Color or race W

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

24

11

hr. min.

9. Birthplace _____

(City, town, or county)

(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____

(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county)

(State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 12-10-1940 (b) _____

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo. (b) County Stoddard

(c) City or town Paris
(If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 14
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____

(Specify type of place)

(e) Means of injury _____

23. Signature John H. Parker (M. D. or other) _____

Address Paris mo Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

44078

Registration District No. 840

Primary Registration District No. 6102

Registrar's No.

1. PLACE OF DEATH:

(a) Country Stoddard
(b) City or town Stoddard
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT
FULL NAME

Dealia M. Payton

3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 54 Months 11 Days - If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 14
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Lung Removal
Due to Bronchitis
Due to no tuberculosis
by X-ray, sputum test
for man's test

Other conditions Chro. Bronchitis
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature Dr. John H. Huber
Address Physician, M.D. Date signed 3, 4, 40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY